STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005052	A. BUILDING: _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN ST FRANCIS HEALTH - MOORESVILLE	1201 HADLEY RD MOORESVILLE, IN 46158

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of two State complaints. Complaint: #IN00159558 Unsubstantiated: Lack of sufficient evidence. #IN00159112 Unsubstantiated: Lack of sufficient evidence. Facility Number: 005052 Survey Date: 03/19/2015 Surveyor: Saundra Nolfi, RN Public Health Nurse Surveyor Franciscan St. Francis Health- Mooresville is in compliance with 410 IAC 15-1.5-5, Medical Staff and 410 IAC 15-1.6.2, Emergency Services, Hospital Licensure Rules. QA: claughlin 03/25/15	S 000		